DEPARTMENT OF THE ARMY
HEADQUARTERS, WALTER REED ARMY MEDICAL CENTER
6900 Georgia Avenue, NW
Washington, DC 20307-5001

WRAMC Regulation
No. 40-105

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Medical Services

Walter Reed Army Medical Center Falls Prevention Policy

1. History. This regulation is the first published on Walter Reed Army Medical Center (WRAMC) Falls Prevention Policy.

2. Applicability. This regulation is applicable to all personnel working in any setting at WRAMC.

3. Purpose. This regulation establishes policies and procedures for falls prevention, fall incidents occurring within WRAMC and inpatients over 18 years of age at risk for falling.

For falls prevention and patient safety initiatives for children/adolescents and those receiving care on the pediatric service/wards, (See appendix A.)

4. References.

a. Morse, J.M. (1997), Preventing Patient Falls, Thousand Oaks, California Sage Publications.

b. Comprehensive Accreditation Manual for Hospitals (CAMH), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), 2001.

c. Walter Reed Army Medical Center Restraint Policy WRAMC Reg 40-7, Use of Physical Restraint in the Medical Surgical Environment, April 2002.

5. Definitions.

a. Fall. An untoward event in which the person comes to rest unintentionally on the floor.

b. Accidental fall. Falls that result from a person slipping, tripping, or having some other mishap. These falls are often caused by environmental factors such as water or urine on the floor.

c. Anticipated physiological falls. Falls that occur to patients identified at risk for falls. Factors including complicated patients such as those with multiple diagnoses, history of a previous fall, a weak or impaired gait, IV/heparin lock, and an ambulation aid may designate a patient at a higher risk for falling.

d. Unanticipated physiological falls. Falls that cannot be predicated. Examples of this type of fall include seizures, fainting, or pathologic fracture.

6. Responsibilities.

a. The Executive Committee of the Medical and Administrative Staff (ECMAS): ensure WRAMC is committed to decreasing falls within the organization.

b. Department Chiefs: Assist the ECMAS in the commitment to decrease falls within the organization.

c. Chief, Nursing Education and Staff Development (NESD): Ensures nursing orientation and education includes the following:

(1) Importance of Falls Prevention.

(2) Assessment for falls risk.

(3) A method to eliminate or decrease falls to include patient/family education.

(4) Recognition of the common causes and types of falls.

(5) Available options for preventing falls.

d. Performance Improvement Office: Track all falls within the facility via WRAMC Form 1811 (Risk Management Quality Improvement Report) and Addenda. Identify trends and initiate improvement strategies to improve care and prevent future occurrences.

e. Service/Section Chief, Clinical Head Nurse and Wardmaster: Responsible for the inspection of all patient care areas for safety issues or concerns.

f. Housekeeping:

(1) While mopping or waxing floors, will place signs and cones to alert all persons of wet and slippery floor.

(2) Will only mop or wax one side of the floor at a time to allow for safe passage.

(3) After completing floor work, safety signs will be removed promptly.

g. Facilities Management: All outpatients/visitors and hospital staff who fall will report to WRAMC emergency room for evaluation. Additionally, all falls will be reported to the Risk Management Office within 24 hours of the incident by documenting on a WRAMC Form 1811 and Addenda.

h. Registered Nurse (RN):

(1) Assess each patient for falls risk within 24 hours of admission.

(2) Reassess each patient for changes in falls risk when there is a change in the patient's status and/or in accordance with (IAW) item 7b.

(3) Implement appropriate interventions and education to eliminate or prevent falls.

(4) Document fall assessment and prevention activities in the patient record.

(5) Educate the patient and family regarding falls risk and prevention.

i. Hospital personnel: All hospital personnel will create and maintain a safe patient care environment to reduce falls.

7. Requirements.

a. All patients receiving care at WRAMC have the right safe environment free from the risks associated with falls.

b. Patients, their families, and health care providers will be educated about patient rights and responsibilities.

c. All hospital personnel will implement falls prevention throughout the institution and across the continuum of care.

d. The performance improvement process will be used to monitor falls and to initiate improvement activities.

8. Policies and Procedures.

a. Patient/Family Rights: Educate patients and family members about falls and preventive interventions on admission. Patient/Family Falls Prevention Brochures may be obtained from publications.

b. Assessing the Patient for Falls Risk: Assess each patient admitted to WRAMC for his or her potential to fall.

(1) Within 24 hours of admission, a registered nurse will assess each patient for their potential to fall using the Morse Fall Scale. Document the assessment in the Nursing Admission Assessment found in the Clinical Information System (CIS). See Appendix b for the Morse Scale and its explanation.

(2) If the patient receives a falls rating score of 45 or greater, the patient will be placed on the Fall Protocol (See page 3 paragraph d). If the falls score is less than 45, the RN may still place the patient on the Falls Protocol based on his/her professional judgment of patient risk.

(3) Each patient will be reassessed for falls risk:

(a) * Note-refer to when there is a change in patient status,

(b) Upon transfer from one ward/unit to another,

(c) According as circumstances may require (PRN),

(d) And/or, at a minimum, every 7 hospital days.

* A change in status is defined as: surgery, an invasive procedure, an actual fall, change in mental status, and significant change in therapeutic regimens or medications.

c. General Patient Care and Safety:

All patients are potentially at risk for falling during their hospital stay. Thus, the following interventions will be implemented upon admission for each patient:

(1) Orient the patient/family to their room and bathroom. Show the patient how to properly use the call bell and place the patient's call bell within easy reach.

(2) Keep all patients beds in the lowest position with the wheels locked. Lock wheels on all wheelchairs and cardiac/geri-chairs when in a stationary position. Place 1-3 bedrails up on the patient's bed, as needed.

Note: Use of all 4-bed rails has been linked to patient injury. If all 4-bed rails are placed in the up position, the patient can be considered restrained. Refer to WRAMC Restraint Policy (WRAMC Reg 40-7) and follow proper procedures for the use of restraint.

(3) Ensure all patients wear snug fitting, non-slip footwear while ambulating.

(4) Ensure hallways and floors remain dry and clear of any obstacles, especially those that may slide or roll. Clearly identify any hazardous areas or obstacles upon which the patient might trip on. Examples include trashcans, laundry containers, computer terminal stands and cords, patient bags, and any personal belongings.

(5) Ensure bedside table with personal items and any ambulatory devices (walkers, canes, etc.) are within easy reach of the patient at all times.

(6) If patient becomes disoriented, attempt reorientation.

(7) Ensure the patient's eyeglasses are clean.

(8) Ensure proper lighting, especially at night.

d. Falls Protocol: Patients who are determined to be at significant risk for falling (scoring a 45 or greater on the Morse Scale) during the initial admission assessment will have the Fall Protocol initiated.

PROTOCOL:

(1) Falls Risk identification: A green armband will be placed on the patient's wrist. A falls risk sign will be placed in a visible area within the patient's room and on the census board to alert staff of the fall potential of this patient. To maintain patient confidentiality, the words "falls risk" will not be used to indicate those at risk for falls.

(2) A patient may be moved to a room closer to the nurse's station to facilitate more frequent and closer observation.

(3) The RN will insure that the patient's physician is aware of the factors influencing the patient's falls risk so that orders written by the physician support activities that will reduce falls risk or falls occurrence.

(4) Both the patient and family will be educated on the potential for falls and provided information on interventions to eliminate and/or decrease falls potential.

(5) During nursing shift report, identify and report all patients deemed at risk for falling.

(6) Offer the patient toileting at least every two hours, before going to bed, upon awakening, and PRN.

(7) Consider using a bed or personal alarm.

e. Care of the Patient who falls: If a patient fall occurs, nursing staff will:

(1) Immediately assess the patient for injury and stabilize as necessary.

(2) Notify patient's physician.

(3) Call for X-rays and/or obtain labs as ordered.

(4) Initiate falls protocol if not already in place.

(5) Document the fall, circumstances, interventions, and outcome in a CIS progress note.

(6) Review safety precautions with patient/family.

(7) Inform all staff of increased risk and communicate incident at nursing shift report.

(8) Complete WRAMC Form 1811 and Addenda and forward to the Performance Improvement Office within 24 hours. (Do not write in the CIS progress note that an 1811 was completed).

9. Education.

a. All Departments of Nursing personnel will receive initial training on the Falls Policy during Nursing Education and Staff Development Orientation.

b. All hospital staff will receive annual education on this policy.

Appendix A

Falls Prevention for the Pediatric Patient

1. Developmental Component

- Upon admission the RN will assess the infant/child's developmental level in regards to falls risk. Changes will be made as the patient's status warrants.
- Do not leave infants, young children, developmentally delayed or cognitively impaired children on treatment tables or scales without hand contact.
- Children four and younger will occupy cribs. If older than 3, child may occupy youth bed if parent is in attendance at all times. Children under 10 will occupy youth beds.
- Use crib with bubbletop if child is at risk for climbing over the rails.
- Children are to wear non-skid footwear at all times.

2. Family Involvement

- Implement appropriate interventions and education to eliminate or prevent falls
- Consistently enforce safety rules and activity limitations

3. Environment of Care

- Maintain surveillance of children in bathtub/shower
- Keep crib sides up and securely fastened. For children less than 10, top side rails are always up; all 4 side rails up while the child is sleeping.
- Lock bed and crib wheels.
- Always keep bed in lowest position.
- Keep call light/bell within patient reach.
- Maintain hand contact while caring for a child in a crib with side rails down.
- Transport infants and children appropriately, hold with proper support, and fasten safety belt on gurney or wheelchair. The RN will determine appropriate mode of transportation.
- Fasten safety belts on high chairs and swings.

Children will be accompanied & supervised by an adult when using the playroom, playground, and computer room. Children 10 years & older who are not falls risk can use the computer room and playroom unattended. Nursing staff will be available to periodically check on the child/children.

See General Patient Care and Safety , paragraph 8c of this regulation.

Use of the Morse Fall Scale is not applicable to the pediatric population.

Any child admitted with a diagnosis consistent with an increased risk of falling in addition to any of the developmental or cognitive conditions stated, would automatically be placed on the WRAMC Falls Prevention Protocol.

Appendix B

Morse Fall Scale

The Morse Fall Scale is a six-item instrument that assesses patient's risk for falling.
See table and scoring guide below.

Item			Score
1. History of Falling	No	0	
	Yes	25	
2. Secondary diagnosis	No	0	
	Yes	15	
3. Ambulatory aid			
None/ bed rest/ nurse assist		0	
Crutches/ cane/ walker		15	
Furniture		30	
4. Intravenous therapy/ heparin lock	No Yes	0 20	
5. Gait			
Normal/ bed rest/ wheelchair		0	
Weak		10	
Impaired		20	
6. Mental status			
Oriented to own ability		0	
Overestimates/forgets imitations		15	
TOTAL SCORE (score of 45 or greater = at risk for falls) Is patient at risk for falls? ☒ Yes ☒ No			

Scoring guidelines (Taken directly from Morse (1997, pp 40-42):

1. History of falling is scored as 25 if the patient has fallen during the present hospital admission or if there was an immediate history of physiologic falls, such as from a seizure or impaired gait prior to admission. If the patient has not fallen, the score is 0. If a person has fallen for the first time, then his/her score is 25.

2. Secondary diagnosis is scored as 15 if more than one medical diagnosis is listed on the patient's chart; if not, score is 0.

Appendix B (continued)
Morse Fall Scale

3. Ambulatory aids is scored 0 if the patient walks without a walking aid (even if assisted by a nurse), uses a wheelchair, or is on bed rest and does not get out of bed all. If the patient uses crutches, a cane, or a walker, this item is scored 15; if the patient walks clutching onto furniture for support, score the item as 30.

4. Intravenous therapy is scored as 20 if the patient has an intravenous apparatus or heparin lock; otherwise score it as 0.

5. Gait is scored as normal, or 0, if the patient walks with the head erect, striding unhesitant and arms swinging freely at side. A weak gait (score as 10) is characterized by the patient walking with head stooped but is able to lift the head while walking without losing balance. Steps are short and the patient may shuffle. The patient may reach for support from furniture while walking, but this is for reassurance and doesn't require that the patient grab onto furniture to remain upright. With an impaired gait (score as 20) the patient may have difficulty rising from the chair, attempting to get up by pushing on the arms of a chair and/or using several attempts to rise. The patient's head is down and he or she watches the ground. The patient's balance is weak and he/she may grab on to furniture or another person or a walking aid for support and can't walk without this assistance. The patient takes short steps and shuffles.

6. Mental status is measured by checking the patient's self-assessment of his/her own ability to ambulate. Ask the patient, " Are you able to go to the bathroom alone or do you need assistance?" If the patient's judgment is consistent with his/her ambulation orders, the patient is categorized as normal and scored 0. If the patient's assessment is unrealistic or does not coincide with ambulation orders, the patient is considered to overestimate his/her abilities and scored as 15.

The scores for each individual item are tallied for a total score.

The proponent for this publication is the Performance Improvement/Risk Management Office. Users are invited to send suggestions and comments on DA Form 2028 (Recommend Changes To Publications and Blank Forms) to Commander, Walter Reed Army Medical Center, ATTN: MCHL-DMAO-PI, Washington, D.C. 20307-5001.

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